PATHOLOGY AND LABORATORY SERVICES

PANEL TESTS

Automated Multichannel Tests

When billing for panels containing automated multichannel tests, performing providers may bill either the panel code or individual test codes, but not both.

The following tests are automated multichannel tests or panels comprised solely of automated multichannel tests:

CPT® codes								
80048	80069	82247	82374	82550	82977	84100	84295	84478
80051	80076	82248	82435	82565	83615	84132	84450	84520
80053	82040	82310	82465	82947	84075	84155	84460	84550

Calculating Payment for Automated Tests

The automated individual and panel tests above are paid based on the total number of unduplicated automated multichannel tests performed per day per patient. Calculate the payment according to the following steps:

- When a panel is performed, the CPT® codes for each test within the panel are determined;
- The CPT® codes for each test in the panel are compared to any individual tests billed separately for that day;
- Any duplicated tests are denied;
- The total number of remaining unduplicated automated tests is counted.

See the following table to determine the payable fee based on the total number of unduplicated automated tests performed.

Number of Tests		Fee
1	Test	Lower of the single test or $10.26
2	Tests	$10.26
3 –12	Tests	$12.59
13 –16	Tests	$16.81

Number of Tests		Fee
17 – 18	Tests	$18.83
19	Tests	$21.80
20	Tests	$22.48
21	Tests	$23.20
22 –23	Tests	$23.91

Calculating Payment for Panels with Automated and NonAutomated Tests

When panels are comprised of both automated multichannel tests and individual nonautomated tests, they are priced based on:

- The automated multichannel test fee based on the number of tests, added to
- The sum of the fee(s) for the individual nonautomated test(s).

For example CPT® code 80061 is comprised of 2 automated multichannel tests and 1 non-automated test. As shown below, the fee for 80061 is **$27.31.**

CPT® 80061 Component Tests	Number of Automated Tests	Maximum Fee
Automated: CPT® 82465 CPT® 84478	2	Automated: $ 10.26
Nonautomated: CPT® 83718	N/A	Nonautomated: $ 16.13
	Maximum Payment:	$ 26.39

Calculating Payment for Multiple Panels

When multiple panels are billed or when a panel and individual tests are billed for the same date of service for the same patient, payment will be limited to the total fee allowed for the unduplicated component tests.

Example:

The table below shows how to calculate the maximum payment when panel codes 80050, 80061 and 80076 are billed with individual test codes 82977, 83615, 84439 and 85025.

Test	CPT® PANEL CODES			INDIVIDUAL TESTS	Test Count	Max Fee
	80050	80061	80076			
Automated Tests	82040 84075 82247 84132 82310 84155 82374 84295 82435 84450 82565 84460 82947 84520	82465 84478	82040(1) 82247(1) 82248 84075(1) 84155(1) 84450(1) 84460(1)	82977 83615	19 Unduplicated Automated Tests	$ 21.80
	84443					$32.98
	85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009					$15.32
		83718				$16.13
				84439		$17.23
Nonautomated Tests				85025 or 85027 and 85004 or 85027 and 85007 or 85027 and 85009 (1)		$ 0.00
					MAXIMUM PAYMENT:	$ 103.46

(1) DUPLICATED TESTS

DRUG SCREENS

The insurer will pay for drug screening conducted in the office setting by a laboratory with a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver and confirmation testing performed at a laboratory not requiring a CLIA certificate of waiver.

Codes that can be billed

Effective 1/1/2011 the department will pay for drug screening using the following CPT® and HCPCS codes:

- 80100, Drug screen, qualitative; multiple drug classes chromatographic method, each procedure.
- 80102, Drug confirmation, each procedure.
- G0431, Drug screen, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class.
- G0434, Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter.

Payment limits

- 80100 and 80102 are only payable to laboratories that don't require a CLIA certificate of waiver.
- G0431 is limited to one unit per day per patient encounter for laboratories with a CLIA certificate of waiver. Laboratories that don't require a CLIA certificate of waiver may bill more than one unit per day per patient encounter.
- G0434 is limited to one unit per day per patient encounter regardless of the CLIA status of the laboratory.

Codes that are not covered

Effective 1/1/2011 the following CPT codes are not covered by the insurer:

- 80101
- 80104

REPEAT TESTS

Additional payment is allowed for repeat test(s) performed for the same patient on the same day. However, a specimen(s) must be taken from separate encounters.

Test(s) normally performed in a series (for example, glucose tolerance tests or repeat testing of abnormal results) don't qualify as separate encounters.

The medical necessity for repeating the test(s) must be documented in the patient's record.

Modifier –91 must be used to identify the repeated test(s). Payment for repeat panel tests or individual components tests will be made based on the methodology described in the Panel Tests section.

SPECIMEN COLLECTION AND HANDLING

Specimen collection charges are allowed as follows:

- The fee is payable only to the provider who actually draws the specimen.
- Payment for the specimen may be made to nursing homes or skilled nursing facilities when an employee qualified to do specimen collection performs the draw.
- Payment for performing the test is separate from the specimen collection fee.
- Costs for media, labor and supplies (for example, gloves, slides, antiseptics, etc.) are included in the specimen collection.
- A collection fee isn't allowed when the cost of collecting the specimen(s) is minimal, such as:
  - A throat culture,
  - Pap smear or
  - A routine capillary puncture for clotting or bleeding time.

Specimen collection performed by patients in their homes isn't paid (such as stool sample collection).

Use CPT® code 36415 for venipuncture. Use HCPCS code P9612 or P9615 for catheterization for collection of specimen.

Complex vascular injection procedures, such as arterial punctures and venisections, are not subject to this policy and will be paid with the appropriate CPT® or HCPCS codes.

Travel **won't be paid** to nursing home or skilled nursing facility staff that performs specimen collection.

Travel **will be paid** in addition to the specimen collection fee when **all** of the following conditions are met:

- It is medically necessary for a provider to draw a specimen from a nursing home, skilled nursing facility or homebound patient, and
- The provider personally draws the specimen, and
- The trip is solely for the purpose of collecting the specimen.

If the specimen draw is incidental to other services, no travel is payable.

Use HCPCS code P9603 to bill for actual mileage (1 unit equals 1 mile). HCPCS code P9604 isn't **covered**.

Handling and conveyance **won't be paid**, (for example, shipping or messenger or courier service of specimen(s)). This includes preparation and handling of specimen(s) for shipping to a reference laboratory. These are considered to be integral to the process and are bundled into the total fee for testing service.

STAT LAB FEES

Usual laboratory services **are covered** under the Professional Services Fee Schedule.

When lab tests are appropriately performed on a STAT basis, the provider may bill HCPCS code S3600 or S3601. Payment is limited to 1 STAT charge per episode (not once per test).

Tests ordered STAT should be limited to only those needed to manage the patient in a true emergency situation. The laboratory report should contain the name of the provider who ordered the STAT test(s). The medical record must reflect the medical necessity and urgency of the service.

The STAT charge will only be paid with the tests listed below.

CPT® Code	CPT® Code	CPT® Code	CPT® Code
80047	81003	84100	85384
80048	81005	84132	85396
80051	82003	84155	85610
80069	82009	84157	85730
80076	82040	84295	86308
80100	82055	84302	86367
80156	82150	84450	86403
80162	82247	84484	86880
80164	82248	84512	86900
80170	82310	84520	86901
80178	82330	84550	86902
80184	82374	84702	86920
80185	82435	84704	86921
80188	82550	85004	86922
80192	82565	85007	86923
80194	82803	85025	86971
80196	82945	85027	87205
80197	82947	85032	87210
80198	83615	85046	87281
81000	83663	85049	87327
81001	83874	85378	87400
81002	83880	85380	89051

HCPCS Code	Abbreviated Description
G0306	Complete CBC, auto w/diff
G0307	Complete CBC, auto
G0431	Drug screen, single class
G0434	Drug screen, multi drug class

TESTING FOR AND TREATMENT OF BLOODBORNE PATHOGENS

The insurer may pay for post-exposure treatment whenever an injury or probable exposure occurs and there is a potential exposure to an infectious disease. Authorization of treatment in cases of probable exposure (not injury) doesn't bind the insurer to allowing a claim at a later date.

The exposed worker must apply for benefits (submit an accident report form) before the insurer can pay for testing and treatment.

Covered Testing Protocols

Testing for Hepatitis B, C and HIV should be done at the time of exposure and at 3, 6, and 12 months post exposure. The following test protocols are **covered**:

Hepatitis B (HBV)

- HbsAg (hepatitis B surface antigen).
- Anti-HBc or HBc-Ab (antibody to hepatitis B core antigen).
- Anti-HBs or HBs-Ab (antibody to hepatitis B surface antigen).

Hepatitis C (HCV)

- Enzyme Immunoassay (EIA).
- Recombinant Immunoblot Assay (RIBA).
- Strip Immunoblot Assay (SIA).

The qualitative reverse transcriptase polymerase chain reaction (RT-PCR) test is the only way to determine whether or not one has active HCV.

The following tests are **covered** services if HCV is an accepted condition on a claim:

- Quantitative reverse transcriptase polymerase chain reaction (RT-PCR).
- Branched-chain DNA (bDNA).
- Genotyping.
- Liver biopsy.

HIV

There are 2 blood tests needed to verify the presence of HIV in blood:

- Rapid HIV or EIA test, and
- A Western Blot test to confirm seropositive status.

The following tests are used to determine the presence of HIV in blood:

- Rapid HIV test.
- EIA test.
- Western Blot test.
- Immunofluorescent antibody.

The following tests are **covered** services if HIV is an accepted condition on a claim:

- HIV antiretroviral drug resistance testing.
- Blood count, kidney, and liver function tests.
- CD4 count.
- Viral load testing.

Post-exposure Prophylaxis for HBV

Treatment with hepatitis B immune globulin (HBIG) and the hepatitis B vaccine may be appropriate.

Post-exposure Prophylaxis for HIV

When a possible exposure to HIV occurs, the insurer will pay for chemoprophylaxis treatment in accordance with the most recent Public Health Services (PHS) Guidelines. **Prior authorization isn't required**.

When chemoprophylaxis is administered, the insurer will pay at baseline and periodically during drug treatment for drug toxicity monitoring including:

- Complete blood count and
- Renal and hepatic chemical function tests

Covered Bloodborne Pathogen Treatment Regimens

Chronic hepatitis B (HBV)

- Interferon alfa-2b.
- Lamivudine.

Hepatitis C (HCV) – acute

- Mono therapy.
- Combination therapy.

HIV/AIDS: Covered services are limited to those within the most recent guidelines issued by the HIV/AIDS Treatment Information Service (ATIS). These guidelines are available on the web at http://aidsinfo.nih.gov/.

Treating a Reaction to Testing or Treatment of an Exposure

The insurer will allow a claim and applicable accident fund benefits when a worker has a reaction to **covered** treatment for a probable exposure.

BLOODBORNE PATHOGEN BILLING CODES

Diagnostic Test/Procedure

CPT® Code
47100
83890
83894
83896
83898
83902
83912
86689
86701
86704
86706

CPT® Code
86803
86804
87340
87390
87521
87522
87901
87903
87904

Treatment Related Procedures

CPT® Code
78725
86360
87536
80076
90371
90746 (adult)
90772-90779

CPT® Code
99201-99215
99217-99220